MIAMI-DADE

Miami-Dade County
MEDICAL, DENTAL & VISION PLANS
STATUS CHANGE FORM

For Office Use Only

FLEX APPROVAL: YES NO

Effective Date:_____

Group #: _____

Employee's Last Name	First	MI	Social Security #

Medical Plan:

Dental Plan:

Vision Plan:

ADDITIONS

SPOUSE
(check appropriate box)
☐ MEDICAL
☐ DENTAL
☐ VISION

Name of spouse	Social Security #	Date of Birth
Date of Marriage	Name of Spouse's Employer	
Dentist Name and Facility #	PCP Name and Provider #	

CHILD
(check appropriate box)
☐ MEDICAL
☐ DENTAL
☐ VISION

Name	Sex	Social Security #	Date of Birth	Relationship	Dental Facility #	PCP Provider #
1)						
2)						
3)						

DELETIONS

COMPLETE FOR DELETIONS Name(s) To Be Deleted (First, M., Last)	Medical/Dental/Vision	Date of Birth	Relationship	Sex
1)	☐ ☐ ☐			☐ Male ☐ Female
2)	☐ ☐ ☐			☐ Male ☐ Female
3)	☐ ☐ ☐			☐ Male ☐ Female
4)	☐ ☐ ☐			☐ Male ☐ Female
REASON FOR DELETION	☐ Age ☐ Divorce ☐ Marriage ☐ Death ☐ Other – *Please explain:*			

OTHER CHANGES	Name of Member	Date of Birth	Dental Facility #	PCP Provider #
CHANGE OF PROVIDER	1)			
	2)			
	3)			

CHANGE OF ADDRESS	New Address (Include Zip Code)	Home Phone Number

CHANGE OF NAME	From:	To:

Signature of Employee	Date